Working with People Diagnosed with "Borderline Personality Disorder"

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"Borderline Personality Disorder? "

1. **What is it?**
2. **How can we be useful to people who have it?**
3. **Crisis intervention and the role of hospital**

Borderline Personality Disorder

Prevalence of BPD in general population:
8 published studies (Torgersen in press)

Median 1.42 %, mean 1.16 %

Estimated

10-20 % in Psychiatric Outpatients

15-20 % in Psychiatric Inpatients

We react negatively to the "borderline" diagnosis

"Having that diagnosis resulted in my getting treated exactly the way I was treated at home. The minute I got the diagnosis people stopped treating me as though what I was doing had a reason."

Judith Herman
Trauma and Recovery

Personality Disorder

A. Pervasive, persistent maladaptive behavior
   - Not attributable to Axis I
   - Medical illness
   - Or cultural role difficulties.

B. We all have different ways of protecting ourselves

C. We all have bits and pieces of effective as well as maladaptive behavior

D. Any label gives very incomplete information

DSM IV Criteria

(American Psychiatric Association, 1994)

A. Avoidance of abandonment
B. Unstable, intense interpersonal relationships
C. Identity disturbance
D. Potentially self-damaging impulsiveness
E. Recurrent suicidal or self-mutilating behavior
F. Affective instability
G. Chronic feelings of emptiness or boredom
H. Inappropriate anger
I. Transient paranoid ideation or severe dissociative symptoms

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Borderline Personality Disorder

I was diagnosed with BPD about 2 years ago. I'm not sure if I really agree with it, but I guess I do fit into the criteria, just not the stereotype. I think that almost everyone on earth could fit into the BPD criteria somehow though. I didn't feel bad about the diagnosis until I started reading about it. Then it seemed to be this horrid curse that labeled me a self-centered, attention-seeking jerk. I don't see myself this way. I hope I am not.

Core Deficits in People with Borderline Disorder

A. Affective Instability

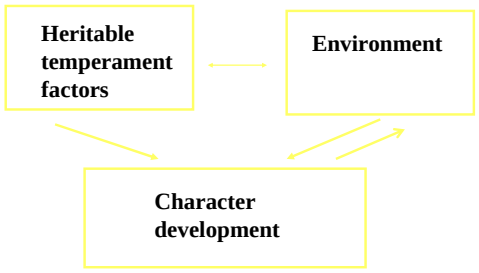
B. Impulsivity and low frustration tolerance

C. Sense of self as being damaged/defective/not good

D. Difficulty maintaining their own sense of identity/poor object constancy

E. Poor understanding of rules of normal interpersonal relationships

Personality



Sexual Abuse and Borderline Disorder

- 40-71 % of people with BPD report childhood sexual abuse
- 19-46% of controls also report childhood sexual abuse
- Most abuse survivors do not develop severe adult psychopathology

Zanarini 2000

McLean 10 year follow-up study

Zanarini 2005

- Prospective study with F/U at 2,4,6,8 and 10 years
- N = 362 inpatients with personality disorder
- 290 met DSM IIIR criteria for BPD
- 92 % of surviving pts with BPD in 10 year data

McLean 10 year follow-up study (cont)

Zanarini 2005

- Almost 90% had remission of BPD
- Recurrence of BPD relatively rare
- 80 % had good psychosocial functioning
- Social functioning less impaired than vocational functioning
- Suicide is substantially less than thought

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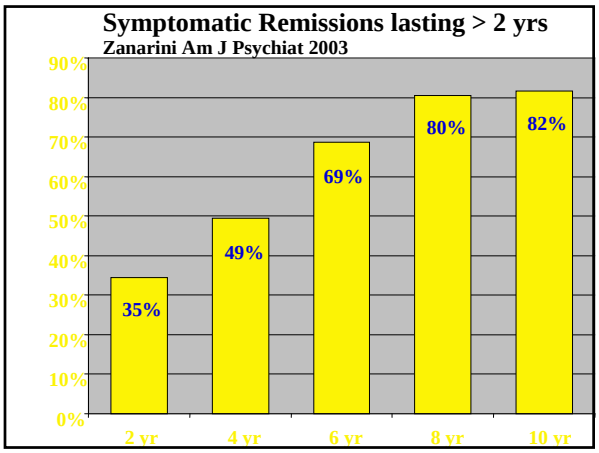

Course of Symptoms

Zanarini et al Am J Psychiat 2003

Completed Suicide:

3.8 % (N = 11) at 10 year follow up

Course of Symptom Change

- Affective symptoms decreased least
- Impulsive symptoms decreased most
- Cognitive and interpersonal symptoms intermediate

Rather be dead!!!.. just venting!

I don't understand how I am supposed to deal with my 'stuff. I don't feel like living this way anymore... I want to s/i so badly but I am afraid that if I don't make it a FINAL act I will have severe consequences to pay and will end up feeling worse. What am I supposed to do with all these feelings? I wish I could just die for a little while. I hate this so much I am so mad and I don't know where to put the blame. Is it my fault that I am borderline and end up fucking up my relationships and just my whole life in general! I think I'd rather be dead! What fucking choices to I have that don't suck!!

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Significance of a "Healing Relationship"

- 45% of patients identified a significant other as responsible for their improvement
- 29% identified a therapeutic relationship as responsible for improvement

Links and Heslegrave 2000

The goal is to stay in a long term, stable relationship:

- Know the limits of your responsibility
- Be aware of your own feelings
- Monitor and regulate interpersonal distance
- Be aware of "splitting"--being "right" may be less important than being a team

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Words that Interfere with Relationship

- Manipulative
- Treatment Resistant
- Unmotivated
- Attention Seeking
- Too ill to know what is good for herself

Support the client's own sense of competence

Supportive Psychotherapy for BPD

Focuses on

- Increasing Self-esteem
- Reducing anxiety
- Enhancing coping mechanisms
  - (Pinsker et al)

Supportive Psychotherapy for BPD

- Conversational but not conversation: goal focused
- Encourages a "real" relationship
- Uses clarification, suggestion, praise, education
- Focus on current life issues: can examine past experiences on current life patterns
- Avoids prolonged silence, neutrality, confrontation
- Induced anxiety is avoided

Hellerstein et al 2004

Supportive Psychotherapy for BPD

- Plan ahead for next predictable event
- Clarify: "it seems that this is an example of the pattern that you find yourself in"
- Education: "this is common with people with BPD"
- "Striking when the iron is cold"
- Address emptiness by direct support

Hellerstein et al 2004

Supportive Psychotherapy for BPD

the magic of "and"

The person may want to kill or cut herself, *and* may also have other choices

Suicide is a choice, *and* there may be other choices

Hellerstein et al 2004

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Assumptions about borderline patients and therapy (from Lenihan)

- Patients are doing the best they can
- Patient want to improve
- Patients need to do better, try harder and be more motivated to change
- Patients may not have caused all of their own problems but they have to solve them anyway

Assumptions about borderline patients and therapy (cont)

- The lives of suicidal, borderline individuals are unbearable as they are currently being lived
- Patients must learn new behaviors in all relevant contexts
- Patients cannot fail in therapy
- Therapists treating borderline patients need support

Treatment planning is critical.

A. Can allow the clinician to be proactive

B. Involve the client

Obtain a Careful History

Many people with a borderline diagnosis have been in the system for years without a careful history

- What has the person tried
- What has gotten in the way
- How has the person responded to problems
- Exceptions when things have gone well, or at least gone a bit better

Consider that problem behavior is exacerbated by:

- Treatable medical illness
- Co-existing mental illness
- Sequel a of trauma
- Always consider substance abuse

Be clear about the therapy contract

A. What does the client want
  - **What are the client's treatment goals**
  - **What would "doing better" or "doing worse" mean**
  - **What commitment is the client willing/able to make**

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Be clear about the therapy contract (cont)

B. What do you want?
- **What are you able to deliver**
- **What can you not tolerate**
  - **Behavior**
  - **Risk**

Core Strategies for Therapy

- Validation
- Problem solving
- Skills training

The importance of hope

- Building motivation
- Getting through the "bad times"

Goal of Treatment: Hierarchy of Change

- **Symptoms**
- **Regulatory mechanisms**
- **Cognitive styles**
- **Some self-attitudes such as self esteem**
- **Interpersonal patterns**
- **Way traits are expressed**

Core personality traits may change little, but self-esteem and behavior can change a lot

Barbara Stanley

Agreement on goals

- What problem behaviors to be addressed
- What would "doing better" and "doing worse" mean
- How to monitor change:
  - Clinician notes
  - Personal diary
- What time course to consider
  - Role of baseline measurement

Psychological Interventions

- Skill training
- Problem solving
- Affect-regulation strategies
- Learning affect tolerance

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Techniques of DBT that can be used in non DBT treatment

- Diary Cards
- Agenda Setting With Focus on Treatment Targets
- Intersession Contact for "in Vivo" Coaching
- Psychoeducation
- Behavioral Analysis Techniques"
- Coping Skill Development
- Clear and Precise Safety Plans

Barbara Stanley

Clinical guides

- Be open to discussing sexual abuse, but make sure it is client's agenda
- Achieve behavioral stability first
- Respect the person's defenses

Risk

- There is no way to treat clients with borderline personality disorder without taking risks
- Need to balance short term Vs long term risks
  - **High lifetime risk of suicide.**
  - **Responding to each suicidal event may make it more difficult for people to stabilize their lives.**

Balancing risks

- Discussed carefully with the client
- The client's family
- Other members of the treatment team and support system

When you are stuck, enlarge the field.

A. Involve other people in the client's support system.

B. Involve other parts of the treatment system.

C. Involve supports and consultants for yourself.

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Crisis Intervention is Critical

Crisis Vs ongoing life chaos
- **Is this a crisis?**
- **Whom is this a crisis for?**
- **What is the crisis?**

Do not get overwhelmed by the client's sense of crisis.

Crisis (cont.)
Suicide is a real risk

- Need to feel pain Vs need to be dead
- Suicidal people do not want to be dead, they just do not want their life to continue as it is
  - **Loss of hope**
  - **Impulsivity and poor object constancy**
  - **Substance use increases suicide risk**
- Suicide involves someone beside patient

Cutting:

I can remember the first time I cut.....it was to see how hard it would be to slice my wrists.... finally I took the chance and tried to kill my self.....it was an odd sensation...I suddenly felt better..... this rush actually saved me. I didn't finish the suicide.... I tried 2 more times within a month...each of these times getting deeper and more dangerous. Again, I would feel better almost immediately.....I found that it was like a drug.

Crisis (cont.)
Be careful about premature problem solving-especially

- Can interfere with relationship
- Can cause client to feel problems are being trivialized
- Can reinforce client's sense of powerlessness
- Often client just wants to be heard

Crisis (cont.)
Plan for crisis Before the crisis

- Involve the client
- What works, what does not
- What can be tried that is different
- Who else can be involved

Role of the hospital

- Clear goals for use of hospital
- Use of crisis homes and other alternatives
- Use of hospital "contracts"

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Role of the hospital

- Crisis model
  - Goal is safety, respite
  - Maximum stay of 2-3 days
- Extended stay
  - Assessment
  - Focused therapy over 2-8 weeks
- Long-term care
  - Goal may be maintenance or treatment

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